REFERRAL FORM
MEDICAL ELIGIBILITY DETERMINATION

Received by: ☐ fax ☐ phone

1. REFERRAL DATE — Month ___ Day ___ Year ____

2. APPLICANT NAME — First: _____ (MI) ____ Last: _____

3. BIRTH DATE — Month ___ Day ___ Year ____

4. GENDER — 1. Male 2. Female

5. MARITAL STATUS — 1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

6. CITIZENSHIP — 1. U.S. Citizen 2. Legal alien 3. Other

7. PRIMARY LANGUAGE — 0. English 1. French 2. Spanish 3. Other

8. RACE/ ETHNICITY *(Optional)* — 1. American Indian/Alaskan 2. Asian/Pacific 3. Black 4. Hispanic 5. White 6. Other

9. RESIDENCE ADDRESS

Street _____

City/Town _____ Cnty _____ State _____

Zip _____ Phone (____) _____

10. MAINECARE NO. *(if applicable)* ☐ 0-NA

11. MEDICARE NO. ☐ 0-NA

12. SOCIAL SECURITY NO.

13. INCOME SUMMARY

Source	Recipient	Amount	Frequency

☐ Not known

14. LEGAL GUARDIAN — Does consumer have a legal guardian? 0-No 1-Yes 2-Not known

15. REFERRAL INFORMATION — Is consumer aware of this referral? 0-No 1-Yes

16. VISUAL/ HEARING
a. Visual Impairment 0-No 1-Yes
b. Hearing Loss 0-No 1-Yes

17. COGNITION/ BEHAVIOR
a. Cognitive Impairment 0-No 1-Yes
b. Behavioral Problems 0-No 1-Yes

18. ADVANCED DIRECTIVES *(For only those items with supporting documentation)* — *(Check all that apply.)*

a. Living will [a]
b. Do not resuscitate [b]
c. Do not hospitalize [c]
d. Organ donation [d]
e. Autopsy request [e]
f. Feeding restrictions [f]
g. Medication restrictions [g]
h. Other _____ [h]
i. NONE OF ABOVE [i]

19A. CURRENT COMMUNITY CARE PLAN ☐ 0-NA

PROVIDER	SERVICE CATEGORY SEE CODING SHEET	FREQUENCY # HOURS/VISITS PER MONTH	DURATION START DATE	DURATION END DATE	FUNDING SOURCE SEE CODING SHEET

19B. HOMEBOUND STATUS (SEE ATTACHED)
1. Certified homebound 0-No 1-Yes
2. Certified homebound exemption 0-No 1-Yes

20. REFERRAL SOURCE
1. Nursing Facility
2. Consumer
3. Family member
4. Hospital
5. BFI
6. Residential Care
7. Provider agency
8. Community agency
9. Advocacy agency
10. Physician
11. Other state agency
12. Other

21. LOCATION AT TIME OF ASSESSMENT
1. Hospital Campus _____ Room # _____
2. Home/apartment
3. Congregate housing
4. Residential Care Facility
5. Nursing Home
6. Assisted Living Unit
7. Adult Family Care Home
8. Adult Foster Home
9. Other

22. PROVIDER REFERRAL
a. Referring Provider/Facility Name ☐ 0-NA
b. Provider Contact Name
c. Telephone No.

23. PERSONAL/ OTHER REFERRAL
a. Referred by (Name) _____ ☐ 0-NA
b. Contact Name (if different)
c. Telephone No.

24. ASSESSMENT TRIGGER
1. Service need
2. Reassessment due
3. Significant medical change
4. Financial change

25. ASSESSMENT TYPE
1. Initial
2. Reassessment Date Due _____

26. PROGRAM ASSESSMENT REQUESTED
1. Long Term Care Advisory
2. Adult Day Care Program
3. BEAS HomeMaker
4. MaineCare Day Health
5. Consumer Directed PCA
6. Home Based Care
7. Phys. Dis. HCB
8. Elderly HCB
9. Adults w/ Disability HCB
10. PDN - Level I, II, III
11. Adult Family Care Home
12. Level V - Extended PDN
13. NF Assessment
14. 20-day Medicare/MaineCare
15. Medicare to MaineCare
16. 20-day copay to NF MaineCare
17. 30-day Community MaineCare NF
18. Advisory to MaineCare Update
19. Adv. Medicare to Private Pay NF
20. Continuing Stay Review
21. Extraordinary Circumstances to NF
22. Katie Beckett
23. NF PDN - Level IV
24. Congregate Housing
25. TBI
26. MaineCare Home Health
27. PDN Medication-Level VI
28. PDN Venipuncture Only-Level VII
29. Consumer Directed HBC

27. NF/HOSPITAL/ HOME HEALTH DATES *(if applicable)*
a. Acute care denial date: _____ ☐ 0 - NA
b. First Non-SNF Date: _____ ☐ 0 - NA
c. Last day private pay: _____ ☐ 0 - NA
d. Late notification date 0 - No 1 - Yes
e. Bed hold expired 0 - No 1 - Yes
f. Admission date: _____ ☐ 0 - NA
g. Discharge date: _____ ☐ 0 - NA
h. Home health end date: _____ ☐ 0 - NA

28. PHYSICIAN
Name _____
Address _____
Telephone _____

29. EMERGENCY OR FAMILY CONTACT
Name _____
Address _____
Relationship _____
Telephone _____
Legal Guardian ☐ Yes ☐ No

30. COMMENTS